

Reg. Dist. No. .... 100 .....

05905

MARGIN RESERVED FOR BINDING

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. This is especially important. Physicians: please write the causes of death clearly and legibly. **The correct age**

WS. A15

PLEASE

1. PLACE OF DEATH- COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		DATE OF DEATH		DATE	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		5. SEX	
6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION					
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
20. AUTOPSY?					
21. ACCIDENT SUICIDE HOMICIDE					
22. I hereby certify that I attended the deceased from ... to ...					
23. BURIAL, CREMATION REMOVAL (Specify)					
24. FUNERAL DIRECTOR					

RECEIVED  
JUN 13 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

05906

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>La Plata, Md.</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Clarence A. Butler</u> (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>June 30 1954</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-29-1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refused - Contracts for Gov't.</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>59</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Butler</u>		14. MOTHER'S MAIDEN NAME <u>Georgianna Jennifer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Carrie Butler, La Plata, Md.</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>6-30-54</u>
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a)	<u>O. rushed Chest</u>		
825.5 Antecedent cause(s) (b)	<u>1700 auto accident</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Re 301</u>	(CITY OR TOWN) <u>Newburg</u>	(COUNTY) <u>Chas</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6 30 51 7 p.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>auto accident</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>R. B. Delen M.D.</u>		ADDRESS <u>La Plata Md.</u>	
DATE SIGNED <u>7-2-54</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>7/3/54</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	LOCATION (City, town, or county) (State) <u>Campbelt, Md.</u>
DATE REC'D BY LOCAL REG. <u>7/3/54</u>	REGISTRAR'S SIGNATURE <u>Julius H. Casey</u>	24. FUNERAL DIRECTOR <u>Hunt + Byon, Waldorf, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05907

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>(RURAL) CHARLOTTE HALL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>(RURAL) CHARLOTTE HALL</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>BESSIE</u> (Middle) <u>LOUISE</u> (Last) <u>FREEMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 1 1951</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE - U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>MARCH 9, 1884</u>
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (State or foreign country) <u>CHARLOTTE HALL, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ALEXANDER MARSHALL FREEMAN</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE ANN LYON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>MISS MARY FREEMAN; CHARLOTTE HALL, MD.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

175X Immediate cause (a) CYST-ADENOCARCINOMA OF LEFT OVARY WITH LOCAL METASTASES 2 1/2 mos  
Antecedent cause(s) (b) ATHERO-SCLEROSIS OF CORONARY ARTERIES 2 years  
49a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>APRIL 20, 1951</u>		19b. MAJOR FINDINGS OF OPERATION <u>CYST-ADENOCARCINOMA (GRADE IV) OF LEFT OVARY</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u> <u>HOMICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from SEPTEMBER 1948, to JUNE 1, 1951, that I last saw the deceased alive on MAY 31, 1951, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>6/4/51</u>		DATE THEREOF <u>6/4/51</u>		NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		LOCATION (City, town, or county) (State) <u>New Port md</u>	
DATE REC'D BY LOCAL REG. <u>6/4/51</u>		REGISTRAR'S SIGNATURE <u>Julia A. Casey</u>		24. FUNERAL DIRECTOR <u>St. Francis</u>		ADDRESS <u>Waldorf md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 413

RECEIVED  
JUN 6 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05908

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 100

1. PLACE OF DEATH— COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE <i>Md.</i> COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Tharion</i> (Middle) <i>Clair</i> (Last) <i>Herd</i>	4. DATE OF DEATH	(Month) <i>6</i> (Day) <i>4</i> (Year) <i>1951</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>6-4-51</i>
9. AGE last birthday		If under 1 year	If under 24 hrs
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>La Plata Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Francis Herd</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Victoria Simms</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>James F. Herd, La Plata, Md.</i>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) *Strangulation - Cord about neck*

Antecedent cause(s)

(b) *Cord gangrenous (black)*

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

406041349406

RECEIVED  
JUN 6 1951  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05909

Reg. Dist. No. 105

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>North Carolina</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raleigh</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Durham</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Phys. Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>1118 Lynchburg St</u>	
3. NAME OF DECEASED (Type or Print) <u>Lonnie</u> (First) (Middle) (Last) <u>Johnson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>6</u> <u>10</u> <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>7-13-07</u>
9. AGE last birthday <u>43</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, if not retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Teacher</u>	<u>Tobacco</u>	<u>Durham, N.C.</u>	<u>U.S.A.</u>
13. FATHER'S NAME <u>McCoy Johnson</u>		14. MOTHER'S M maiden name <u>Stella Winston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>2245-0921-83</u>	
		17. INFORMANT AND ADDRESS <u>Glady's Johnson 1118 Lynchburg St Durham</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Hemorrhage and shock</u>			
Antecedent cause(s) (b) <u>Fracture of base of skull</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>825.5</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF (Office bldg., etc.) IN (City or town)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6-9-51 2P</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR? <u>Auto accident 6-9-51</u>	
22. I hereby certify that I attended the deceased from <u>6-10-51</u> , 19 <u>51</u> , to <u>6-10</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>6-10</u> , 19 <u>51</u> , and that death occurred at <u>330</u> m. from the causes and on the date stated above.			
SIGNATURE <u>E. J. Edelen M.D.</u>		DATE SIGNED <u>6-10-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE <u>6/11/51</u>		<u>Washington D.C. Washington D.C.</u>	
DATE REC'D BY LOCAL REG. <u>6-11-51</u>		24. FUNERAL DIRECTOR ADDRESS <u>Phanth &amp; Pilon 2000 1st St N.W. Washington D.C.</u>	

820106 Trayner Turner Home Washington D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

Called State Police, Bel. 7102 for information about "place of accident"  
They have record of Leonard Johnson, same address, 6/9/51, signed by same  
doctor; They do not have a record of Lonnie Johnson, as is being investigated.  
Leonard Johnson was killed in an accident on Rte 5, 7 mi. east of T.B., in  
Prince George's Co. 6/9/51/

mcw 12/27/51

JUN 14 1951

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

05910

Reg. Dist. No. 100

1. PLACE OF DEATH- COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MARYLAND</b> COUNTY <b>CHARLES</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <b>WASHINGTON BOULEVARD</b>	
3. NAME OF DECEASED (Type or Print) (First) <b>SAMUEL</b> (Middle) <b>—</b> (Last) <b>McDONALD</b>	4. DATE OF DEATH (Month) <b>JUNE</b> (Day) <b>14</b> (Year) <b>1951</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED - U.S.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>NOV. 22, 1908</b>
9. AGE last birthday <b>42</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>	
11. FATHER'S NAME <b>JOHN McDONALD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <b>LENA (UNKNOWN)</b>	
15. SOCIAL SECURITY No. <b>240-09-7211</b>		17. INFORMANT AND ADDRESS <b>MATILDA McDONALD (WIFE); LA PLATA, MD.</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <b>CORONARY THROMBOSIS</b>		<b>1 HOURS</b>	
Antecedent cause(s) (b) <b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>		<b>2 YEARS</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <b>John H. Griffin, M.D.</b>		ADDRESS <b>Hughesville, Maryland</b> DATE SIGNED <b>6/14/51</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>June 17-51</b>		NAME OF CEMETERY OR CREMATORY <b>Newtown ME</b> LOCATION (City, town, or county) <b>Rural La Plata MD</b> (State)	
DATE REC'D BY LOCAL REG. <b>6/16/51</b>		24. FUNERAL DIRECTOR <b>Hunt &amp; Ryon</b> ADDRESS	

970246

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED

JUN 20 1951

BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05911

Reg. Dist. No. 100

1. PLACE OF DEATH COUNTY <u>CHARLES</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>BENEDICT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BENEDICT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>THOMAS</u>		4. DATE OF DEATH <u>JUNE 2</u> 19 <u>51</u>	
(First) (Middle) (Last)		(Month) (Day) (Year)	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED-U.S.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Sept 23 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Freightman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Freightman</u>	9. AGE last birthday <u>77</u> yrs. If under 1 year: Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Benedict Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Plater</u>		14. MOTHER'S MAIDEN NAME <u>Nellie Mack</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>6/4/51</u>	
17. INFORMANT AND ADDRESS <u>Mary A Plater</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Cerebro-Sclerotic Heart Disease, Cardiac

Antecedent cause(s)

Failure

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

General Cerebro-Sclerosis

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Sept......, 1947., to June 2., 1951., that I last saw the deceasedalive on June 1., 1951., and that death occurred at 9:15 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John N. Griffin, M.D. Hughesville 6/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>6/5/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	LOCATION (City, town, or county) <u>Brightons Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>6/4/51</u>	REGISTRAR'S SIGNATURE <u>Julia H. Casey</u>	24. FUNERAL DIRECTOR <u>North &amp; Ryan</u>	ADDRESS <u>Waldorf, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A131

910126

RECEIVED  
JUN 6 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05912

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hayside md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hayside md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Martha L. Ryan</u>		4. DATE OF DEATH (Month) <u>6</u> (Day) <u>28</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Aug 30-1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	9. AGE last birthday <u>83</u> yrs. If under 1 year Months Days Hours Mln.
11. FATHER'S NAME <u>Samuel H. Carter</u>		12. CITIZENSHIP <u>USA</u>	
13. MOTHER'S MAIDEN NAME <u>Matilda Moore</u>		14. INFORMANT AND ADDRESS <u>Ruth Howard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a).....

myocardia

INTERVAL BETWEEN ONSET AND DEATH  
1 month

Antecedent cause(s) (b).....

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

#### 20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-25, 1951, to 6-28, 1951, that I last saw the deceased

alive on 6-28, 1951, and that death occurred at 11 A.m., from the causes and on the date stated above.

SIGNATURE

Emil S. Ryan M.D.

ADDRESS

Bel Air Md

DATE SIGNED

6-28

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

6-30-51

M.L. Moore

St. Ann's City of Waldorf Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



16

COPY SENT TO BUREAU

RECEIVED  
JUL 3 1961  
BUREAU A. B.

DATE 7-3-51



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05913

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>La Plata Chas Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>West Virginia</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Charles</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chattanooga</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>114 - Bradford</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GOLDIE</u>	(Middle) <u>RACHEAL</u>	(Last) <u>SCHOENBAUM</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	4. DATE OF DEATH (Month) <u>6</u> (Day) <u>24</u> (Year) <u>1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	8. DATE OF BIRTH <u>APR. 29 - 1879</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> If under 24 hrs: Hours <u>  </u> Min. <u>  </u>
13. FATHER'S NAME <u>Emile Boris</u>	11. BIRTHPLACE (State or foreign country) <u>LITHUANIA (RUSSIA)</u>	12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY No. <u>NO</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		17. INFORMANT AND ADDRESS <u>Olaf Schoenbaum Son</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>MULTIPLE FRACTURES OF RIBS, STERNUM, COSTAL CARTILAGES WITH HEMOTHORAX AND MEDIASTINAL HEMORRAGE</u>	<u>5 DAYS</u>
Antecedent cause(s)	(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>	<u>2 YRS.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>DIABETES MELLITUS</u>	<u>3 YRS.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>ACCIDENT</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Automobile</u>	(CITY OR TOWN) <u>WHITE PLAINS</u> (COUNTY) <u>CHARLES</u> (STATE) <u>M.D.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>6</u> <u>19</u> <u>51</u> <u>1:30 pm.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Automobile Accident</u>

22. I hereby certify that I attended the deceased from 6-19, 1951, to 6-24, 1951, that I last saw the deceased alive on 6-24, 1951, and that death occurred at 8:10 A.M. EST, from the causes and on the date stated above.

SIGNATURE J. Warren Jarboe M.D. ADDRESS La Plata, Maryland DATE SIGNED 6-24-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>6/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Charleston N.Y.</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. <u>6/25/51</u>	REGISTRAR'S SIGNATURE <u>Julius H. Pacey</u>	24. FUNERAL DIRECTOR <u>Arthur J. Ryan</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AJP

RECEIVED  
JUN 26 1952  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05914

## CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH- COUNTY <u>Charles.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bryans Road.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bryans Road.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Thelery Ann Thompson</u>		4. DATE OF DEATH <u>June 1 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10-30-83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	9. AGE last birthday <u>68</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Fenwick Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wesley Marbury</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Neal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Steyman Thompson, Bryans Road, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

acute myocarditis

Antecedent cause(s)

(b)

Hypertensive Heart Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
SUICIDE	INJURY			
HOMICIDE				
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF	White at Not White			
INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from....., 1948, to June 1, 1951, that I last saw the deceased alive on June 1, 1951, and that death occurred at 3:25 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>6-5-51</u>	<u>Metropolitan N.E. Church</u>	<u>Pomonkey</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>6-1-51</u>	<u>M.E. Ransome Deputy</u>	<u>Mathews &amp; Barnes</u>	<u>Washington D.C.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 10 1951  
BUREAU A. B.